emailed validation letter 11/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10.11.11
Amount ~~$ 100.-~~ Ck#03695

I. IDENTIFICATION

Name: LP Albany llc dba Clinton Care and Rehabilitation Centre

Address: 404 N. Washington Street

City/County/Zip: Albany, KY 42602

Telephone number: 606-387-6623

Administrator: Logan Midkiff

Date facility operation began at current address: 6/0//2008

Date facility began operation under current owner: _____

RECEIVED
OCT 11 2011
OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	52	52
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit XX	Individual
County	Nonprofit	Partnership
City		Corporation LLC
Private XX		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

(OVER)

10/31

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Albany, LLC

Address of corporation 12201 Bluegrass Parkway Louisville, KY 40299

President or Chairman N/A

Vice President N/A

Secretary N/A

Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. None

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. None

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. None

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
LP CS Holding, LLC	Signature Consulting Service., LLC
12201 Bluegrass Parkway	Signature Clinical Consulting Service LLC
Louisville , KY 40299	12201 Bluegrass Parkway Lou, KY 40299

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative | CFO Title | Date

Return Application and fee to: Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)